STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011555	A. BUILDING: _____ B. WING _____	12/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF KOKOMO	329 W RAINBOW DR KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure survey. Survey dates: December 22, 23, and 24, 2014 Facility number: 011555 Provider number: 011555 AIM number: N/A Survey team: Bobette Messman RN TC Gloria Bond RN (December 22, 2014) Census bed type: Residential: 26 Total: 26 Census payor type: Private: 26 Total: 26 Sample: 9 Primrose Retirement Community of Kokomo was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review 12/28/14 by Lisa McColly	R 000		